The Chronicle

TOUCH PAD BODY: A NEW HEALTH LITERACY AND INTERPRETING TOOL

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There are many different Health Promotion resources available in remote communities. In our research with interpreters and health workers in Arnhemland[1], we have identified the need for a new and different resource for helping health workers, medical staff, interpreters, patients and their families come to shared understandings and agreed ways forward for treatment.

A health literacy and interpreting tool

How is it unique?

We propose that this Touch-pad Body will differ from other similar objects in that it will:

- be a 3D zoomable touch-pad animated figure of a human body – on something like an iPad
- incorporate multi-touch gesture navigation
- not contain any embedded health messages (ie not didactic)
- represent a biomedical human body
- be non-sequential (ie have few embedded sequences, and depend upon users in conversation for its navigational logic)
- focus first on aspects of the healthy body and pathology leading up to chronic disease and treatment
- be produced and evaluated collaboratively by workers in the field, developing its features and functionality in response to the particular questions which arise in contexts of sharing understandings and making agreement.

We have found that:

- It is most useful to work from an Aboriginal definition of communication as building shared understandings[2] rather than a western definition based on the transfer of information from one person to another
- health literacy resources that contain health messages seldom promote the sorts of conversations which promote a productive ongoing dialogue and collaboration between health professionals, service users and their families
- we need to take seriously Aboriginal clients' knowledge and understandings of their own bodies, and find a balance between their knowledge and the biomedical system.

The style and type of representations we will use in posters and leaflets. This image also presents an imagined scenario of the product in use.

A Strategy

This new Touch-pad Body – does not teach biomedical certainties. We could introduce it into health literacy and interpreting practice as a conversation generator that has a capacity for generating a focus on several bodily functions – heart and lungs, kidney, ears etc. Its versatility and vagueness allows for the top-down and bottom-up practices to work together in new ways. It allows for a 'both-ways' (re)negotiation of the categories through which health professionals, interpreters, clients, and their families work together. Our aim would be to use knowledge work around the Touch-pad Body to examine, unsettle and interrupt received notions of health, disease and treatment on both sides of the health care delivery context to create new understandings, engagement and commitments. →

Training Uses

While theTouch-pad Body will have no text or sound in conversational settings it would be easy and useful to sometimes add text and sound files for example for interpreter and health worker training. This will help health staff learn English anatomy and physiology terms, and give them confidence taking the lead using the tool in cross-cultural consultations.

See **www.cdu.edu.au/hl**, and **www.cdu.edu.au/centres/yaci/projects_health_mmedia.html**

This definition came from Yolŋu researchers in the Sharing the True Stories project. See **www.cdu.edu.au/stts**

Northern Territory Government | DEPARTMENT OF HEALTH

ARE WE WAITING FOR GODOT?

Dr Leonie Katekar, Chief Rural Medical Practitioner
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It is no longer a matter of 'if' or 'when' the health sector is going to computerise clinical information and workflow. It is clearly 'now', 'what' and 'how'.

On a recent study tour, jointly funded by the National eHealth Transition Authority, Royal Australasian College of General Practitioners and the National Health Call Centre Network, I had the privilege of speaking to the leading clinicians in several overseas countries where significant national investments have been made in computerisation of the health sector.

Investment - yes, but progress – not so uniformly successful. Indeed, the most common theme was about the resistance from the clinical communities, most prominently, resistance from those medically trained.

In contrast, at the World Health Assembly in Geneva in May 17, the Taiwanese Ministry for Health, Chair of the World Medical Association, Surgeon General of the USA and others talked of ehealth as been as transformative to health care as the discoveries of antibiotics and DNA. But clearly grass-roots clinicians across the world are not all, and many not at all, convinced that computerisation is adding any value at all to the business of being a health care provider.

The reasons for clinician resistance are obvious and well known, so it is not worth repeating here, however it is neither unexpected nor unexplained. Resistance to change is common place, especially to transformative ideas, for example like the car to the horse and cart and the supermarket trading philosophy to the apple growers in the Huon Valley Tasmania. Those that adopted late were left behind. I am one of those who believe that ehealth will be transformative to the health sector and clinical workflow.

Without clinicians taking a driving seat in ehealth, products and 'solutions' are steered by politics, politicians and those who work in ICT. For example, the HealthConnect funding was distributed to various jurisdictional Information Divisions who developed million dollar projects around sending out politically desirable discharge summaries electronically. Failure was due to the obvious problem that it is not that the discharge summaries are sent by FAX or POST but that they are not even generated in the first place. Sending by email is a political bandaid but lack of insight into the cause of the problem by the politicians and bureaucrats extended from the funders to the receivers of the funding.

This is the kind of thing that is still happening overseas and is largely the cause of the lack of progress in countries. Where there is a lack of appropriate clinical leadership, ehealth is not delivering something useful for the clinicians.

Although I hear a litany of complaints from clinicians here in the NT, in comparison, the NT is a place where computerisation of the business of health care is extensively progressed. In the NT we have the SEHR, PCIS, CCIS, PACS, CWS, Continuity of Care Project, Telehealth Project, Advanced eShared Care Planning – amongst other things. The progress is built on the Information Division ensuring that there is clinical input in each of these projects and programs - but they struggle to get enough input. If our ehealth systems are going to work for us, clinicians need to be involved at multiple levels – executive leadership, clinical reference groups, business requirements analysis, functional specifications development and assisting with change management and training.

We can't really expect clinical information management software to go from nothing to iphone 4 maturity without some years of painful growth. Are we waiting for the invention of an iphone 4 or a Lexus of a clinical information system to come across our desks? Or are we waiting for a clinical information system that will not require us to change our behaviours? If we are, we are waiting for Godot.

Lack of clinical leadership in ehealth leaves the money in the hands of those who clinicians distrust the most. Don't wait for Godot, if you aren't already, get involved now!